Health Care Financing Notes

Medicare: Use of Skilled Nursing Facility Services, 1979

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Health Care Financing Notes

The Health Care Financing Administration was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review Organization program, and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 47 million of the nation's aged, disabled, and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

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The purpose of the ***Health Care Financing Notes*** is to provide the public with descriptive program data or information as soon as it becomes available. Data are presented here in a brief, concise format. Frequently a more comprehensive analysis of the data may be available at a later time in one of the Health Care Financing Administration's other publications.

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Medicare: Use of Skilled Nursing Facilities, 1979

By Martin Ruther

This *Note* presents data on the use of and payments made to skilled nursing facilities (SNFs) under Medicare during 1979. Trend data for the years 1969 to 1979 are also shown.

To receive reimbursements under Medicare, an SNF must be certified as possessing the staff and equipment to provide skilled nursing or rehabilitation services as well as other related services. In addition, the facility must have a transfer agreement with one or more hospitals participating in the program.

Skilled nursing facility coverage under Medicare's hospital insurance (HI) program is limited to 100 days of SNF care in a benefit period. In 1979 Medicare enrollees were responsible for a $20 a day SNF coinsurance payment for the 21st through the 100th day of care.[1] In contrast, the Medicaid program which finances medical care for the needy has no limit on days of SNF care or coinsurance requirements. Also, Medicare enrollees eligible for Medicaid are reimbursed for SNF Medicare coinsurance amounts and for SNF stays beyond 100 days.

Persons eligible for SNF services are reimbursed under Medicare's hospital insurance (HI) program if all of the following five conditions are met: (1) the patient was in a hospital at least three consecutive days (not counting the day of discharge) before transfer to a certified SNF, (2) transfer to the SNF is required for the continued care of the condition which was treated in the hospital, (3) admission to the SNF takes place within 14 days of discharge from the hospital (an additional 14 days may be allowed if the patient could not be admitted to an SNF because of a shortage of SNF beds in the geographic area, or if the patient's condition makes it medically inappropriate to begin an active course of treatment in the SNF), (4) a physician certifies to the patient's need for and the patient receives skilled nursing or skilled rehabilitation services on a daily basis, and (5) the facility's utilization review committee or the local Professional Standards Review Organization does not disapprove the stay.

Based on bills processed through June 1980 for services approved for reimbursement in 1979, total Medicare reimbursements were approximately $28 billion. As shown in this *Note,* Medicare reimbursements for SNF services were about $318.5 million, or about 1.2 percent of the total.[2] This stands in contrast to the experience of the Medicaid program which finances health care services to the needy. In fiscal year 1979, total Medicaid expenditures for nursing home services, which include payments for skilled nursing and intermediate care facilities, were $8.6 billion, or about 42 percent of the total—$20.5 billion.

The contrast between the Medicare and Medicaid programs in payment for nursing home services is even more striking when attention is fixed solely on persons 65 years and over, the group with the largest use of nursing home services.

Medicare payments for SNF services to the aged in calendar year 1979 were, as of June 1980, about $306 million (or 1.3 percent) out of a total of $23.9 billion for all covered services to the aged. Medicaid expenditures for nursing home services to the aged in fiscal year 1979, were $4.1 billion out of total expenditures of about $7.7 billion—or 53 percent of the total. Of the combined payments for nursing home services by the two programs, Medicaid paid 93 percent. Clearly, Medicaid is the dominant public source of payments for nursing home services to the aged.[3]

The limited role of the Medicare program in covering the cost of nursing home services derives from the program's focus on meeting the cost of episodes of illness. The skilled nursing care benefit is conceived as a post-hospital extension of care for recovery from an illness when continuous medical care in a hospital is no longer required (see below). The Medicare program's limits on meeting the institutional costs required for the treatment of an acute illness in contrast to the care required for long-term disabilities is embodied in the concept of the "benefit period". A benefit period begins when the patient is admitted to a hospital and ends when a patient has been out of a hospital or a skilled nursing facility for 60 consecutive days.

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[1] The hospital insurance (HI) program pays for all covered hospital services for the first 60 days of a benefit period less the HI deductible. From the 61st through the 90th day in a benefit period, the patient pays a coinsurance equal to one-fourth of the HI deductible. For care beyond the 90th day, the patient may draw on a lifetime reserve of 60 days. For lifetime reserve days, the patient pays a coinsurance equal to one-half the HI deductible. In 1979, the HI deductible was $160.

This Note was written by Martin Ruther of the Program Statistics Branch, Herbert A. Silverman, Chief. It is one of a series prepared by the Office of Research, Judith R. Lave, Director, to provide a description and analysis of the use and cost of health care benefits furnished to the beneficiaries of the Medicare and Medicaid programs administered by the Health Care Financing Administration. The report was written under the administrative supervision of Allen Dobson, Director, Division of Beneficiary Studies.

[2] Both reimbursement amounts will be greater as later bills are processed and retroactive adjustments to providers are made upon audit of cost reports (see Source and Limitations of the Data). However, the percentage is expected to remain about the same. SNF reimbursements have been below 2 percent of total Medicare reimbursements since 1975 and have been decreasing.

[3] Computations based on data of services incurred in 1977 indicate that private out-of-pocket payments by or on behalf of the aged constituted half of all payments to nursing homes for services to the aged. See "Medicare: Health Insurance for the Aged and Disabled, 1976-78; Summary, Utilization and Reimbursement by Person" (in preparation) Health Care Financing Administration.

In contrast, the Medicaid program permits coverage of a patient's care in a skilled nursing and intermediate care facility for an indefinite period as long as the level of care requirements are met.

This *Note* provides data on the number of covered days of care, covered charges, and reimbursements from 1969 through 1979 (Table 1). Similar data are shown by State of residence of aged beneficiaries using SNF services during 1979 (Table 2). State data are shown only for the aged since they accounted for 96 percent of the total amount reimbursed by Medicare for SNF services in 1979. The remaining benefits were for disabled enrollees under 65 years of age who were entitled to cash benefits for at least 24 consecutive months under the disability insurance program, and to certain persons with end-stage renal disease. Medicare coverage to the disabled began July 1, 1973.

Highlights of the data follow.

Use and Cost of Skilled Nursing Facilities, 1969–1979

Aged

- The aged used 17.9 million covered days of SNF care in 1969, but, because of regulations issued in 1969 which tightened the criteria for Medicare coverage of SNF services, the number of covered SNF days used by the aged dropped to 6.5 million by 1972. Between 1972 and 1979 the covered days of SNF care used by the aged increased to 8.1 million. Thus, between 1969 and 1979, the use of covered SNF days declined at an average annual rate of 7.7 percent, but, between 1972 and 1979 SNF covered days used by the aged increased at an average annual rate of 3.2 percent from the low point of 6.5 million covered days.
- Covered days of care per 1,000 enrolled fell from 892 in 1969 to 303 in 1972 and has shown only a slight increase to 323 days per 1,000 enrollees by 1979.
- Covered charges for SNF services decreased from $431 million in 1969 to $207 million in 1972. Charges increased steadily from 1973 until they reached $505 million in 1979. Between 1969 and 1979, the average annual rate of increase of covered charges was 1.6 percent, but the rate of increase between 1972 and 1979 was 13.6 percent per year.
- Covered charges per day in SNFs rose from $24 to $62 in the 1969-1979 period, an annual rate of increase of 10.0 percent.
- Reimbursements for SNF services were $336 million in 1969, and fell to $159 million in 1972. Reimbursements generally increased since 1972 and were $306 million in 1979. SNF reimbursements to the aged were 1.8 of hospital insurance reimbursements and 1.3 percent of total reimbursements in 1979.
- For the 1969-1979 period, SNF reimbursements declined at an overall annual rate of 1.0 percent, but between 1972 and 1979, reimbursements increased at an average annual rate of 9.8 percent.
- Reimbursements as a percent of covered charges fell from 78.1 percent in 1969 to 60.5 percent in 1979, an average annual decline of 2.5 percent. The decline indicates that covered charges have been rising faster than the reasonable (allowed) costs upon which Medicare reimbursements are based. This may reflect, in part, the provisions of the 1972 Amendments to the Social Security Act which mandated that Medicare would pay for services at the lesser of reasonable costs or customary charges. This led to broad increases in the charge schedule for many SNF services in subsequent years.
- Reimbursements for SNF services per hospital insurance enrollee fell from $16.80 in 1969 to $7.53 in 1972 and rose after that to $12.45 in 1979. Between 1969 and 1979 reimbursements per enrollee declined at an annual rate of 2.7 percent, but, between 1972 and 1979, the average annual increase was 7.5 percent.
- Reimbursement per day of SNF care increased from $19 to $38 between 1969 and 1979, an average annual increase of 7.2 percent.
- In 1979, the aged (vs. the disabled) used 96.3 percent of all the days of SNF care covered by Medicare.

Disabled

- Covered days of care increased from 266,000 in 1974 (the first full calendar year of coverage of the disabled) to 307,000 in 1979, an annual increase of 2.9 percent.
- Covered days of care per 1,000 enrolled declined an average of 5.3 percent a year, from 138 to 105 in the 1974-1979 period. In 1979, covered days per 1,000 enrolled among the disabled were less than one-third of those of the aged.
- Covered charges increased from $10.9 million to $21.8 million between 1974 and 1979, an average annual increase of 14.8 percent.
- Covered charges per day increased from $41 to $71 in the same period, or an annual rate of increase of 11.6 percent. Covered charges per day of the disabled have consistently exceeded that of the aged, suggesting greater intensity in the use of SNF services.
- Reimbursements as a percent of covered charges declined from 69.6 percent in 1974 to 59.3 percent in 1979, a decline of 3.2 percent annually.
- Reimbursements per enrollee increased an average of 2.4 percent a year, from $3.94 in 1974 to $4.44 in 1979.
- Reimbursement per day increased at an annual average of 7.7 percent or from $29 in 1974 to $42 in 1979.

Use and Cost of SNF Services by State of Residence, 1979

State differences in use of SNF services focus on the use by the aged since, as stated earlier, 96.3 percent of the SNF days of care covered by Medicare were used by the aged.

- By State, use of SNFs varied considerably. California had the highest number of covered days of care, 863,000, or 11 percent of all covered days in SNFs. In contrast, Alaska, with only five participating SNFs, recorded about 1,000 days of care (Table 2).

- Hawaii had the highest number of covered days per 1,000 enrolled, 685, and Mississippi the lowest, 56 per 1,000.

There were large variations in rates of use and reimbursement for SNF services by region.

- Covered days of care per 1,000 enrolled were 392 in the North Central States and 280 in the South.
- In all other rates in this report the West was highest and the South lowest:
  - Covered charges per day were $69 in the West and $55 in the South.
  - Reimbursement as a percent of covered charges was 66.7 in the West and 58.5 in the South.
  - Reimbursement per enrollee was $16.48 in the West and $8.98 in the South, and
  - Reimbursement per day was $46 in the West and $32 in the South.

Source and Limitations of the Data

Data in this report are derived from a 100 percent count of billing forms submitted by participating SNFs for reimbursable inpatient SNF services. Data for 1969-1979 are based on records processed and recorded as of June 27, 1980. As a result, figures recorded in recent years are slightly less complete than those of earlier years.

Payments under the HI program which are shown in this *Note* are based on interim reimbursement rates reported on processed bills. The interim rates are established to reflect current costs as closely as possible. These are usually established as a per diem amount or as a percentage of total charges. Figures shown exclude amounts for which the patient is responsible such as deductibles, coinsurance, and charges for noncovered services. The final amount of reimbursement due under Medicare to each provider of medical services is determined after the end of the fiscal year on the basis of the providers' audited reasonable cost of operations. It is estimated that the total shown in this report for the covered days of care and reimbursements are approximately 95 percent of the eventual totals. The rates and averages shown may be less than would prevail were completed data available. Thus, comparisons of rates should be taken as indicative of differences by relevant characteristics rather than as final measures of the rates themselves.

Figures for 1979 are based on bills processed through June 27, 1980 which were *approved* for payment in calendar year 1979, plus some few bills which were processed from July 1979 through June 1980—with approval for payment prior to calendar year 1979. A major report using more complete data and based on the period SNF services were *incurred* is in preparation.

Acknowledgement

Data for this report come from the Medicare Statistical System which is designed and maintained by the Division of Data Production, Office of Statistics and Data Management. Special appreciation is due to Jim Welsh for the SNF data systems and file design and to Larry Chrest for computer services and programming for the current utilization data.

TABLE 1

Use of Skilled Nuraing Facility Sarvicea by Aged and Disablad Enrollees: Covered Days of Care, Covered Charges, and Reimbursement by Period Approved, 1969-1979 1/

Period Approved 2/	Covered Daya of Care		Covered Chargea		Reimbursement			
	Numbar (in Thousanda)	Per 1,000 Enrolled	Amount (in Thousanda)	Per Day	Amount (in Thousands)	Percent of Covered Chargea	Per Enrollee	Per Day
			All Enrolleea 3/					
1969	17,936	892	$430,636	$24	$336,225	78.1	$16.80	$19
1970	11,202	547	300,884	26	230,264	76.5	11.31	21
1971	7,711	369	233,070	30	180,096	77.3	8.68	23
1972	6,470	303	206,781	31	158,948	76.9	7.53	25
1973 3/	8,012	340	261,016	32	195,561	74.9	8.39	24
1974	8,977	371	323,594	36	237,421	73.4	9.92	26
1975	9,079	364	419,170	46	265,738	63.4	10.78	29
1976	9,683	377	455,722	47	301,205	66.1	11.90	31
1977	9,601	363	489,952	51	313,945	64.1	12.03	33
1978	8,820	325	498,022	56	310,584	62.4	11.60	35
1979	8,376	301	527,107	62	318,507	60.4	11.60	38
Averags Annual Rate of Change, 1969-1979	-7.3	-10.3	2.0	10.0	-0.6	-2.5	-3.6	7.2
			Aged					
1969	17,936	892	$430,636	$24	$336,225	78.1	$16.80	$19
1970	11,202	547	300,883	26	230,263	76.5	11.31	21
1971	7,711	369	233,063	30	180,091	77.3	8.68	23
1972	6,470	303	206,760	31	158,935	76.9	7.53	25
1973	7,950	364	258,756	32	193,903	74.9	8.99	24
1974	8,711	391	312,665	35	229,821	73.5	10.45	26
1975	8,789	386	404,774	46	256,185	63.3	11.40	29
1976	9,370	403	438,608	46	290,316	66.2	12.67	31
1977	9,273	389	470,484	50	301,875	64.2	12.86	33
1978	8,519	350	478,398	56	298,626	62.4	12.45	35
1979	8,069	323	505,296	62	305,577	60.5	12.45	38
Average Annual Rate of Change, 1969-1979	-7.7	-9.7	1.6	10.0	-1.0	-2.5	-2.7	7.2
			Disabled 3/					
1974	266	138	$10,920	$41	$ 7,596	69.6	$3.94	$29
1975	288	133	14,322	49	9,502	66.3	4.38	33
1976	313	131	17,117	54	10,891	63.6	4.55	35
1977	328	125	19,469	59	12,070	62.0	4.61	37
1978	301	108	19,623	65	11,958	60.9	4.28	40
1979	307	105	21,810	71	12,931	59.3	4.44	42
Averags Annual Rate of Change, 1974-1979	2.9	-5.3	14.8	11.6	11.2	-3.2	2.4	7.7

1/ Includea only those bills recorded in the Health Care Financing Administration central records before June 27, 1980.
2/ Period in which the intermediary approved bills for payment. Usually more than one bill is submitted for each stay in an SNF. As a result, figurea recorded in recent yesra are slightly less complete than that of earlier years.
3/ Data for July-December 1973, the start of coverage for the disabled, included with all enrolleea but not shown for disabled.

TABLE 2

Use of Skilled Nursing Facility Services by the Aged: Covered Days of Care, Covered Charges, and Reimbursements by Area of Residence for 1979 for Claims Approved as of June 27, 1980

Area of Residence	Covered Days of Care		Covered Charges		Reimbursement			
	Number (in Thousands)	Per 1,000 Enrolled	Amount (in Thousands)	Per Day	Amount (in Thousands)	Percent of Covered Charges	Per Day	Per Enrollee
All Areas[1]	8,069	329	$505,296	$63	$305,577	60.4	$38	$12.45
United States[2]	8,056	335	504,060	63	304,839	60.4	38	12.66
Northeast	1,924	330	128,618	67	76,118	59.1	40	13.07
North Central	2,530	392	157,308	62	92,954	59.0	37	14.38
South	2,171	280	119,112	55	69,714	58.5	32	8.98
West	1,431	357	98,995	69	66,034	66.7	46	16.48
New England	364	249	26,833	74	17,663	65.8	49	12.09
Maine	36	260	3,283	92	2,262	68.9	63	16.34
New Hampshire	53	530	3,969	75	2,506	63.1	47	25.07
Vermont	16	281	900	57	492	54.6	31	8.66
Massachusetts	145	209	12,989	89	8,521	65.6	59	12.26
Rhode Island	46	380	2,678	59	1,865	69.6	41	15.42
Connecticut	69	197	3,014	43	2,017	66.9	29	5.76
Middle Atlantic	1,559	357	101,785	65	58,455	57.4	37	13.40
New York	587	284	42,073	72	23,245	55.2	40	11.23
New Jersey	275	334	19,298	70	11,513	59.6	42	14.00
Pennsylvania	697	475	40,414	58	23,697	58.6	34	16.14
East North Central	2,017	466	120,806	60	68,961	57.1	34	15.95
Ohio	630	562	38,898	62	22,912	58.9	36	20.43
Indiana	216	383	11,402	53	6,492	56.9	30	11.50
Illinois	620	516	40,273	65	22,342	55.4	36	18.60
Michigan	439	496	24,023	55	13,793	57.4	31	15.59
Wisconsin	113	205	6,210	55	3,421	55.0	30	6.20
West North Central	512	239	36,502	71	23,993	65.7	47	11.22
Minnesota	71	152	6,077	85	4,157	68.4	59	8.91
Iowa	91	240	6,366	70	4,421	69.4	49	11.65
Missouri	191	307	15,387	81	10,004	65.0	52	16.05
North Dakota	45	567	1,858	41	971	52.2	22	12.23
South Dakota	15	168	738	50	396	53.6	26	4.42
Nebraska	56	278	3,513	63	2,362	67.2	42	11.71
Kansas	44	148	2,563	58	1,683	65.6	38	5.65
South Atlantic	1,407	356	74,336	53	42,804	57.5	30	10.82
Delaware	19	333	841	45	473	56.2	25	8.30
Maryland	133	367	6,951	52	4,187	60.2	31	11.54
District of Columbia	18	272	1,035	57	644	62.2	36	9.72
Virginia	107	229	6,955	65	3,807	54.7	36	8.14
West Virginia	53	236	3,076	58	1,715	55.7	32	7.63
North Carolina	260	467	12,134	47	6,929	57.1	27	12.44
South Carolina	100	383	4,163	42	2,086	50.1	21	7.98
Georgia	81	172	5,220	65	3,255	62.3	40	6.93
Florida	636	427	33,960	53	19,708	58.0	31	13.22

(continued)

TABLE 2 (Continued)

Use of Skilled Nursing Facility Services by the Aged: Covered Days of Care, Covered Charges, and Reimbursements by Area of Residence for 1979 for Claims Approved as of June 27, 1980

Area of Residence	Covered Days of Care		Covered Charges		Reimbursement			
	Number (in Thousands)	Per 1,000 Enrolled	Amount (in Thousands)	Per Day	Amount (in Thousands)	Percent of Covered Charges	Per Day	Per Enrollee
East South Central	531	345	$26,971	51	$15,389	57.0	$29	$10.00
Kentucky	206	534	10,867	53	6,068	55.8	29	15.74
Tennnessee	150	313	8,858	59	4,861	54.8	32	10.14
Alabama	160	394	5,829	37	3,595	61.6	22	8.84
Mississippi	15	56	1,417	93	865	61.0	58	3.24
West South Central	233	103	17,805	76	11,521	64.7	49	5.08
Arkansas	18	62	1,339	73	692	51.6	38	2.38
Louisiana	53	144	3,453	65	2,026	58.6	38	5.51
Oklahoma	40	115	4,459	112	3,222	72.2	81	9.23
Texas	122	97	8,554	70	5,582	65.2	46	4.43
Mountain	258	259	15,464	60	10,589	68.4	41	10.69
Montana	40	485	1,584	40	956	60.3	24	11.59
Idaho	23	254	899	39	599	66.5	26	6.61
Wyoming	5	136	259	47	167	64.3	33	4.54
Colorado	40	171	2,861	71	2,183	76.3	55	9.34
New Mexico	9	84	669	71	384	57.4	43	3.59
Arizona	63	228	4,278	68	2,892	67.6	46	10.46
Utah	46	442	3,067	66	2,201	71.7	48	21.17
Nevada	31	522	1,846	60	1,206	65.3	39	20.31
Pacific	1,173	388	83,531	71	55,445	66.3	47	18.38
Washington	136	332	7,309	54	4,612	63.1	34	11.27
Oregon	125	431	8,168	65	5,184	63.4	41	17.86
California	863	386	64,354	75	43,344	67.3	50	19.36
Alaska	1	98	113	83	65	57.9	65	6.35
Hawaii	47	685	3,588	76	2,239	62.4	48	32.61
Puerto Rico	12	47	1,141	97	683	59.9	57	2.69

[1] Includes residence unknown, foreign, Guam, Virgin Islands, and other outlying areas.
[2] Includes residence unknown.

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Health Care Financing Notes

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